MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

CERTIFICATE OF DEATH

★ 10049 Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Fountain Green Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ½ hour
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Rocks
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James Leroy Alloway

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1942

8. AGE: Years	Months	Days	If less than one day
4	0	2	hrs. min.

9. Birthplace Fawn Grove Pa
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Willard Alloway
13. Birthplace New Park Pa

MOTHER 14. Maiden name Lorena V. McLaughlan
15. Birthplace Raineloe W. Va.

16. Informant Mrs Willard Alloway
Address Rocks md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 10. 46 (month) (day) (year)
Cemetery or crematory Jarrettsville
Location Jarrettsville md
18. Funeral director Martin E Kurtz
Address Jarrettsville Md.

19. 10/9 1946 Priscilla Lowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1946, to October 8, 1946
and that I last saw h/M alive on October 8, 1946

Immediate cause of death	DURATION
LARYNGO-TRACHEA-BRONCHITIS	1 WEEK
Due to	
Due to	
Other conditions EMERGENCY TRACHEOTOMY	10 MIN.

(Include pregnancy within 3 months of death)

Major findings of operations NONE
Date of op.
Autopsy results NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robt A. Barthe M.D.
M. D. or other
Address FOREST HILL, MD. Date signed Oct 8, 1946

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

- THIS BOUNDARY LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

10041

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 336 Wilson
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Louise Boddy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widow

6.(b) Name of husband or wife James Boddy (dec.)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 83			..... hrs. ..... min.

9. Birthplace Maryland (town, county, and state)
10. Usual occupation Housewife
11. Industry or business —

FATHER
12. Name Henry Miller
13. Birthplace Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace Maryland

16. Informant Morris Boddy (Son)
Address 336 Wilson Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/1/46 (month) (day) (year)
Cemetery or crematory Conowingo Colored
Location Conowingo, Md.
18. Funeral director Pennington & Son
Address Havre de Grace Md.

19. Nov. 1 19 46 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 29 19 46, at 5:30 p. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 21 19 46 to Oct 29 19 46
and that I last saw her alive on Oct 29 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	10-21-46
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Claude L. Dowan M. D. or other
Address Havre de Grace Date signed 10-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

Reg. Dist. No. 1085

...THE CORPORATE LIMITS OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 117

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Joseph L. Brown

3. (b) Social Security Number 422-03-5465

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Jane Brown

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) September 21, 1887

8. AGE: Years 59 | Months | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Georgia (Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER 12. Name Minor L. Brown

FATHER 13. Birthplace Ga.

MOTHER 14. Maiden name Eula Sanford

MOTHER 15. Birthplace Ga.

16. Informant Mrs. Minnie L. Brown

Address Meridian, Texas

17. B-Removal (Burial, cremation, or removal. Which?) Date thereof Oct 24 1946 (month) (day) (year)

Cemetery or crematory

Location Meridian Bosque Co. Texas

18. Funeral director R. Madison Mitchell

Address Havre de Grace, Md.

19. Oct 19 1946 (Date rec'd by registrar) E. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1946 at 4:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1946 to Oct 18 1946.

and that I last saw h... alive on Oct 18 1946.

Immediate cause of death	DURATION
Carcinoma of neck	
Due to Fungus Squamous cell	
Primary carcinomal of neck, extending	
Due to into angle of jaw. Cause R.	
Duration 8 months	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Chester J. Foley M.D. M. D. or other

Address Havre de Grace Date signed 10/18/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10043

Reg. Dist. No. 18-5

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County: HARFORD

City or town: HAVRE de GRACE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 HOURS

Hospital, Institution, or street address where death occurred:
HARFORD MEMORIAL HOSP.

How long in hospital or institution? 10 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Cedar
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: SELMA YEVONNE BUNN

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1946

8. AGE: Years	Months	Days	If less than one day
	1	13	____ hrs. ____ min.

9. Birthplace: Edgewood, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Dewey Marby Bunn
13. Birthplace: N. Carolina

MOTHER
14. Maiden name: Evelyn M. Jones
15. Birthplace: W. Va.

16. Informant: Dewey M. Bunn (Father)
Address: 5 Cedar St. Edgewood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/18/46 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Oct. 17 19 46 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH: Oct. 17 19 46, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____

and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
MALNUTRITION	
DEHYDRATION	
Due to FEEDING PROBLEM	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H. Ramsey M.D.
Dep. Medical Examiner or other

Address: Aberdeen, Md. Date signed: Oct. 17, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

10044

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: High St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: AMOS SYLVESTER DAVIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 2nd 1896

8. AGE: Years: 50 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Harrisburg Pa.
(Town, county and state)

10. Usual occupation: Huckster

11. Industry or business

MOTHER FATHER
12. Name: George M. Davis
13. Birthplace: Idaville Adams Co. Pa.

MOTHER
14. Maiden name: Ida Day
15. Birthplace: Idaville Adams Co. Pa.

16. Informant: Jesse V. Giegler
Address: 1420 N. 2nd St. Harrisburg Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 12, 1946 (month) (day) (year)

Cemetery or crematory: Steelers Church Cemetery
Location: Progress, Dauphin Co. Pa.

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.

19. Oct 10 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8 1946 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Intracranial Hemorrhage	
Basal Fracture of Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Oct. 8, 1946
Where did injury occur? Aberdeen Harford Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): U.S. Route # 40
Means of injury: auto accident Injured at work? no

23. SIGNATURE: J. W. Lamar M.D.
Deputy medical Examiner
M.D. or other
Address: Aberdeen, Md. Date signed: Oct 8, 1946

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

CERTIFICATE OF DEATH

10045

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 S. Market

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hiram S. Deibert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary E. Deibert

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 21, 1866

8. AGE: Years	Months	Days	If less than one day
80	5	15	hrs. min.

9. Birthplace Pennsylvania (town, county, and state)

10. Usual occupation Ship Carpenter

11. Industry or business

FATHER 12. Name Henry G. Deibert

FATHER 13. Birthplace Pennsylvania

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace "

16. Informant Mary E. Deibert (wife)

Address 401 S. Market St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/46 (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md.

18. Funeral director Pennington & Son

Address Havre de Grace

19. Oct. 8 1946 C. L. Lewis M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1946, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1946, to Oct 6 1946

and that I last saw h[illegible] alive on Oct 6 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arterial Sclerosis	
Other conditions Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas J. Foley M.D. M. D. or other

Address Havre de Grace Date signed 10/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10046

Reg. Dist. No. 18

1. PLACE OF DEATH:
County: Harford
City or town: Near Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 11 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of motber)
State: Maryland County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest towu)
Street No.: Rural - Near Aberdeen
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Irvin Drayton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Jennie B. Foster
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1877

8. AGE: Years	Months	Days	If less than one day
69	11		hrs. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Paper hanger & painter
11. Industry or business
MOTHER FATHER 12. Name: John Drayton
13. Birthplace: Phila., Pa.
MOTHER 14. Maiden name: McGaw
15. Birthplace: Scotland
16. Informant: George Irvin Drayton
Address: Aberdeen, Md. R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 30 1946 (month) (day) (year)
Cemetery or crematory: Grove
Location: Aberdeen, Md.
18. Funeral director: Henry Jarrett & Son
Address: Aberdeen Md.
19. Oct 29 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1946 at 11:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1946 to Oct 27 1946
and that I last saw him alive on Oct 27 1946
Immediate cause of death: Congestive heart failure — DURATION: 2 days
Due to: Arteriosclerotic heart disease with auricular fibrillation — 1 year
Due to:
Other conditions: Cerebral thrombosis — 1 week
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Peter P. Robinson M.D. M. D. or other
Address: Aberdeen, Md. Date signed: Oct 29, '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-Q)

CERTIFICATE OF DEATH

10047

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Perryman Md
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: William F. Greiner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name ~~of husband or~~ wife: Maude E. Smith
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 15. 1872

8. AGE:

Years	Months	Days	If less than one day
74	2		..... hrs. ..... min.

9. Birthplace: Easton, Pa.
(Town, county, and state)
10. Usual occupation: Interior Decorator
11. Industry or business:
FATHER 12. Name: George Greiner
13. Birthplace: Germany.
MOTHER 14. Maiden name: Unknown.
15. Birthplace: Germany
16. Informant: Miss Ellen D. Smith
Address: Aberdeen R.F.D. #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16 1946 (month) (day) (year)
Cemetery or crematory: Cedarvale Chapel
Location: Near Aberdeen.
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.
19. Oct. 15 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1946, at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 14 1946
and that I last saw h.m. alive on Oct 13 1946

Immediate cause of death	DURATION
Cardio Renal Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H.K. Delaney M.D.
M. D. or other
Address: Perryman Md Date signed: Oct 14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

10048

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Whiteford, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: William R. Hopkins

3. (b) Social Security Number: 217-05-5541

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Laura Hopkins
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1902

8. AGE: Years	Months	Days	If less than one day
43	9	7	hrs. min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Robert P. Hopkins
13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Sue Lincoln
15. Birthplace: York Co. Pa.
16. Informant: Mrs. Mary Little
Address: Whiteford, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5 1946 (month) (day) (year)
Cemetery or crematory: Slate Ridge cemetery
Location: Delta, Pa.
18. Funeral director: Hubert P. Hopkins
Address: Delta Pa.
19. Oct 4 1946 M. D. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2nd 1946, at 11 oc A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30th. 1946, to Oct 2nd 1946
and that I last saw h... alive on October 2nd 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions Pneumoconiosis (Slate)	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jonathan C. Hunt M.D.
M. D. or other
Address: Bel Air, Md. Date signed: 10/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

10049

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James H Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife: Alberta Westcott Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace: St Paul Minn. (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: UNKOWN
15. Birthplace: UNKNOWN

16. Informant: Alberta W Johnson
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 7/1946 (month) (day) (year)
Cemetery or crematory: Hendon Hill
Location: Near Bel Air, Md
18. Funeral director: Dean & Foster
Address: Bel Air, Md

19. 10/6 1946 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4th 1946, at 8.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Oct 1946
and that I last saw him alive on Oct 4th 1946

Immediate cause of death	DURATION
Coronary Myocardial failure or	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Bel Air Md Date signed 10/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-a

CERTIFICATE OF DEATH

10050

Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford

City or town Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No. Paradise Road
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Sarah E. Johnson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

8.(b) Name of husband or wife Samuel G. Johnson

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 29-1883

8. AGE:

Years	Months	Days	If less than one day
63	10		hrs. min.

9. Birthplace Perryman Harford Co. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Harts

13. Birthplace Md.

MOTHER 14. Maiden name Mary Dalham

15. Birthplace Harford Co.

16. Informant Mrs. Cordelia V. Bridgley

Address Aberdeen Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19-1946 (month) (day) (year)

Cemetery or crematory Union M. E.

Location Near Aberdeen Md.

18. Funeral director Beverly Tepping & Sons

Address Aberdeen Md.

19. Oct. 19 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1946 at 5:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1946 to Oct 16 1946 and that I last saw her alive on Oct 16 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	10-5-46
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Claude L. Owens M. D.
M. D. or other

Address Havre de Grace Date signed 10-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

10051

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 18 S-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hrs.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Baby Johnston #2 (twin)

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W.	infant —

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 30, 1946.

8. AGE:

Years	Months	Days	If less than one day
—	—	—	6 hrs. ..... min.

9. Birthplace Havre de Grace Harford - Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name William E. Johnston
13. Birthplace Md.

MOTHER
14. Maiden name Mary Davis
15. Birthplace Md.

16. Informant Harford Memorial Hospital
Address Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1946 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18. Funeral director T. Madison Mitchell
Address Havre de Grace Md.

19. 10-1-46 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1946 at 2304 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1946 to Oct 1 1946 and that I last saw h. l.m. alive on Oct 1 1946

Immediate cause of death	DURATION
Prematurity.	24 wks
Due to prolapse of cord.	pregnancy
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Urchert M.D. M. D. or other
Address Havre de Grace Date signed Oct 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10052

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-24)

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days.
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Kelley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1946

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace Havre de Grace (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER — 12. Name James G. Kelley
13. Birthplace Rockford, Alabama

MOTHER — 14. Maiden name Cora C. Pardue
15. Birthplace Rockford Alabama

16. Informant James G. Kelley (Father)
Address Elkridge Rowing Ground Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 10/24/46 (month) (day) (year)
Cemetery or crematory Liberty Hill
Location Rockford, Alabama

18. Funeral director Pennington & Son
Address Havre de Grace

19. Oct-22 1946 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10, 21 1946 at 12:00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/19 1946 to 10/21 1946 and that I last saw h[illegible] alive on 10/21/46 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 day
Due to Difficult labor	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dudley Phillips Md
M. D. or other
Address Harford Mem. Hosp. Date signed 10/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
OCT 24 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-C)

CERTIFICATE OF DEATH

10053

Reg. Diat. No. 180

1. PLACE OF DEATH:

County: Harford

City or town: Magnolia
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mountain Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Krell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Anna Krell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 19, 1878

8. AGE: Years	Months	Days	If less than one day
68	5	27	..... hrs. ..... min.

9. Birthplace (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Conrad Krell

13. Birthplace

MOTHER 14. Maiden name: Elizabeth Zinicon

15. Birthplace

16. Informant: Mrs. Anna Krell

Address: Joppa, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 20, 1946 (month) (day) (year)

Cemetery or crematory: St. Stephens

Location: Bradshaw, Md.

18. Funeral director: Howard K. McCompae & Son

Address: Abingdon, Md.

19. Oct. 20, 1946 (Date rec'd by registrar) Mae Mc Pendale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1946, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Fracture skull	30 mi
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 10/16/46

Where did injury occur? Joppa (City or town) Harford (County) Md (State)

Injured at home, farm, industry, public place (where?) U.S. Route 40

Means of injury: Hit by auto Injured at work? No

23. SIGNATURE: Gerald C Palmer M.D. Acting Deputy Medical Examiner
Harford County
M. D. or other

Address: Bel Air Md. Date signed 10/16/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-C)

CERTIFICATE OF DEATH

10054

Reg. Dist. No. 185

WITHIN CORPORATE LIMITS OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hrs.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro Infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 666 Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Baby Girl Leahey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-10-46

8. AGE: Years | Months | Days | If less than one day: 15 hrs. 30 min.

9. Birthplace Havre de Grace Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William E. Leahey
13. Birthplace Mass.

MOTHER
14. Maiden name Luise Horton
15. Birthplace Mass.

16. Informant Wife - E. Leahey
Address Bump Apt. Chm St. Havre de Grace

17. Burial Date thereof Oct. 13 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Johns
Location Worcester, Mass.

18. Funeral director Cunningham & Son
Address Havre de Grace, Md.

19. Oct. 11 1946 G. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1946, at 5 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 10 1946 to Oct 11 1946
and that I last saw h er alive on Oct 11 1946

Immediate cause of death	DURATION
Hemorrhagic disease of the newborn	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emil Wollert M D
M. D. or other
Address Havre de Grace Date signed Oct 11 1946

MARYLAND STATE DEPARTMENT OF HEALTH

10055

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Harrisville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Harrisville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3. (a) FULL NAME: James Buchanan Luckey

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Rebecca Lowe
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Nov 5 1855

8. AGE:

Years	Months	Days	If less than one day
90	11	4	hrs. min.

9. Birthplace: Black House Harford Co Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: Joshua G Luckey
13. Birthplace: Black House md.
MOTHER 14. Maiden name: Mary Lytle
15. Birthplace: Black House md
16. Informant: Mrs Rebecca Luckey
Address: Fawn grove Pa
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-11-1946 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Mudonna Harford co md
18. Funeral director: Martin L Kurtz
Address: Jarrettsville md.
19. Oct 11 1946 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1946 at 4:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Oct 8 1946
and that I last saw h. alive on Oct 8 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward H. Hyson M.D.
M. D. or other
Address: Fawn Grove, Pa Date signed Oct. 9 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

★ 10056 Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford Co
City or town: Emmorton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Emmorton, Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ramsey Lee Magness

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Sadie H. Magness
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 10 - 1866

8. AGE: Years: 80 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Emmorton, Harford Co., Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Albert S Magness
13. Birthplace: Md

MOTHER
14. Maiden name: Amanda DeMoss
15. Birthplace: Md

16. Informant: Mrs Sadie H Magness
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16/46 (month) (day) (year)
Cemetery or crematory: Jerusalem Christian
Location: Jerusalem Harford Co. Md

18. Funeral director: W F Archer
Address: Benson Md

19. 10/14 19 46 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13 19 46, at 3 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Oct 19 46 to 13 Oct 19 46 and that I last saw him alive on 13 Oct. 19 46

Immediate cause of death	DURATION
Cardiac Failure	
Due to Chronic Asthmatic Bronchitis & Emphysema	10-15 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles Richardson Jr. M.D.
M. D. or other
Address: Bel Air, Md Date signed: 14 Oct 46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (142)

CERTIFICATE OF DEATH

10057/80
Reg. Diat. No.

1. PLACE OF DEATH:
County: HARFORD
City or town: ABINGTON – RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred:
B & O. RR. TRACKS
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: HARF. BALTO.
City or town: BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7528 LANG ST.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN MANSER, JR.,

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Married

6.(b) Name of husband or wife: Lenola Mauser
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 23, 1913

8. AGE: Years: 33 | Months: 8 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pittsburgh Pa
(Town, county, and state)

10. Usual occupation: Cafeteria Supervisor

11. Industry or business

FATHER
12. Name: John Mauser Sr.
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Ida Gehring
15. Birthplace: Tyrnau

16. Informant: Mrs Lenora J Mauser
Address: 7528 Lang St Baltimore 24

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16, 1946 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Baltimore Maryland

18. Funeral director: Wm Cook, Inc.,
Address: Baltimore Maryland

19. Oct 15 1946 (Date rec'd by registrar) Mae M Mouledoux Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12 1946, at NOT KNOWN M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 18.....

Immediate cause of death	DURATION
HEMORRHAGE	
Due to: BILATERAL LACERATIONS OF NECK	
Due to:	
Other conditions: COMPOUND FRAC OF SKULL -EVISCERATION OF BRAIN	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of injury: 10/12/46
Where did injury occur? NEAR ABINGTON (City or town) HARFORD (County) Md. (State)
Injured at home, farm, industry, public place (where?): R.R. TRACKS
Means of injury: PROBABLY KNIFE OR RAZOR Injured at work? No

23. SIGNATURE: Jos Lawrence M.D.
Dep. M.C. Examiner
Address: Aberdeen, Md. Date signed: 10/14/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-22)

CERTIFICATE OF DEATH

★ 10058

Reg. Dist. No. 18 1

1. PLACE OF DEATH:
County Harford
City or town Havre-de-Grace Md. R.D. 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Havre-de-Grace Md. R.D. 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No

2.(a) If veteran, name war

3. (a) FULL NAME Hannah E. Mitchell

3. (b) Social Security Number No

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Wm. R. Mitchell
Dead
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): July 18, 1865
8. AGE: Years 81 | Months 2 | Days 24 | If less than one day ..... hrs. ..... min.
9. Birthplace: Harford Co. Md. (town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home
FATHER 12. Name: Homer Dunton
FATHER 13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Emily Curry
MOTHER 15. Birthplace: Harford Co. Md.
16. Informant: Mrs. Arthur Andrews
Address: Havre-de-Grace Md. R.D.
17. Burial (Burial, cremation, or removal? Which?) Date thereof Oct 11 1946 (month) (day) (year)
Cemetery or crematory: Rock Run Cem
Location: Harford Co. Md
18. Funeral director: H. L. Bailey
Address: Darlington, Md.
19. Oct. 11 1946 (Date rec'd by registrar) Bertha B. Knight Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9 1946, at 11 30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4 1946, to Oct 9 1946
and that I last saw h... alive on Oct 4 1946

	DURATION
Immediate cause of death: Cerebral hemorrhage	9 Hours
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. E. Gallion M. D. or other
Address: Darlington Date signed 10/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-25

2-1810 ——————————————— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

2

10059

Reg. Dist. No. 1800

1. PLACE OF DEATH:

County Harford

City or town Rural - Abingdon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ludwig W Morkosky

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ella W.,

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1892

8. AGE: Years	Months	Days	If less than one day
54	5	29	hrs. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual occupation Garage Proprietor

11. Industry or business

FATHER 12. Name John Morkosky

13. Birthplace Czechoslovakia

MOTHER 14. Maiden name Francis Morkosky

15. Birthplace Czechoslovakia

16. Informant Mrs. Ella W. Morkosky

Address Abingdon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2, 1946 (month) (day) (year)

Cemetery or crematory Loudon Park,

Location Baltimore Md.

18. Funeral director Howard K. McComas & Son

Address Abingdon Md.

19. Nov 2 1946 (Date rec'd by registrar) Mary M Monkedale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1946 19 46, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Lamey M.D.
Dep. Medical Examiner M. D. or other

Address Aberdeen, Md. Date signed Oct. 30, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

CITIES INCORPORATED LIMITS DO

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 10069 188-

1. PLACE OF DEATH:
County HARFORD
City or town HAVRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 HOURS
Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
How long in hospital or institution? 4 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
AUSTRALIA County
City or town RICHMOND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 171 S. ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CARL F OLOFSSON

3.(b) Social Security Number 560-36-8501

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 60			hrs. min.

9. Birthplace Unknown (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace
MOTHER 14. Maiden name
MOTHER 15. Birthplace
16. Informant Harford Memorial Hosp.
Address Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12-46 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace, Md.
19. Oct. 11 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1946, at 6:28 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death INTRACRANIAL HEMORRHAGE	
Due to FRACTURE OF SKULL	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ACCIDENT Date of Oct. 8, 1946
Where did injury occur? NEAR ABERDEEN HARFORD Md.
(City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ROUTE # 40
Means of injury AUTO ACCIDENT injured at work? No

23. SIGNATURE J. H. Lamar M.D.
Dep. M.C. Examiner M. D. or other
Address Aberdeen, Md Date signed Oct. 8, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10061 181

Reg. Dist. No.

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 yrs.
Hospital, institution, or street address where death occurred: West Bel Air Ave.,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen. (If outside city or town limits, write RURAL and give nearest town)
Street No.: West Bel Air Ave., (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Rebecca L. Orr

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: John W. Orr
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov. 7, 1864

8. AGE: Years	Months	Days	If less than one day
81	11		hrs. ..... min.

9. Birthplace: Aberdeen, Harford Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William P. Greenland
13. Birthplace: Harford Co., Md.
MOTHER 14. Maiden name: Cassandra Greenland
15. Birthplace: Harford Co., Md.
16. Informant: Miss Mamie J. Greenland
Address: 111 Baltimore St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 25 1946 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace Md.
18. Funeral director: Henry T. Jarrett & Sons.
Address: Aberdeen - Md.
19. Oct 24 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22 1946, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1946, to Oct. 22 1946
and that I last saw h.. alive on Oct. 21 1946

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Senile dementia	
Due to Malnutrition.	
Bronchial pneumonia; two days.	
Due to Age and mental condition.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: Thos. P. Thomson M. D. or other
Address: Aberdeen Md Date signed: Oct 27/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175-2

CERTIFICATE OF DEATH

10062

Reg. Dist. No. 186

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours 30 min

Hospital, institution, or street address where death occurred:
Station Hospital, Edgewood Arsenal, Md.

How long in hospital or institution? 6 hours 30 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: ~~XXXXXXX~~ Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME
Osborne, Robert L.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ruby

Bel Air, Md. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 22 March 1914

8. AGE: Years	Months	Days	If less than one day
32	7	8	..... hrs. ..... min.

9. Birthplace: Grayson, Va.
(Town, county, and state)

10. Usual occupation: Technician

11. Industry or business

FATHER
12. Name: Leonard Osborne
13. Birthplace: Va.

MOTHER
14. Maiden name: Hall
15. Birthplace: Va.

16. Informant: Ruby Osborne
Address: Bel Air Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Nov. 1, 1946 (month) (day) (year)

Cemetery or crematory: Reins-Sturdivant,

Location: Independence, Va.

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Md

19. Nov 1, 1946 (Date rec'd by registrar) Marie M Mouldsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 October 1946 at 8:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3:45 30 October 1946 to 8:25 30 Oct 1946 and that I last saw him alive on 30 October 1946

Immediate cause of death	DURATION
extensive third degree burns of body	6½ hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 30 Oct 46

Where did injury occur? Edgewood Arsenal, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: WP Bomb explosion Injured at work? Yes

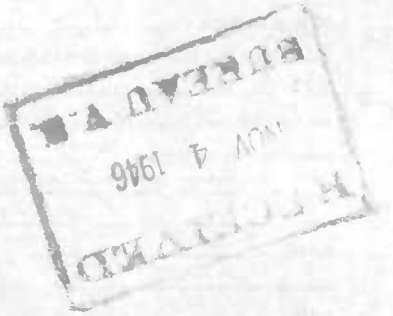
23. SIGNATURE: FRANK L. VANNI, Capt., MC
M. D. or other

Address: Station Hospital, EA, Md. Date signed: 31 Oct 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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Evidence for the additon of information is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

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CERTIFICATE OF DEATH

★ 10063

Reg. Diat. No. 180

1. PLACE OF DEATH:

County Harford

City or town Rural - Edgewood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, Institution, or street address where death occurred:
B & O RR. Camp near Joppa

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State S. C. County Cherokee

City or town Gaffney
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Dever Dugar Pennington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mrs. Hughey Pennington

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1901

8. AGE: Years	Months	Days	If less than one day
45	8	2	....hrs. ....min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual occupation Rail road employee

11. Industry or business cook

MOTHER FATHER
12. Name C. E. Pennington
13. Birthplace South Carolina

MOTHER
14. Maiden name Jannette Blanton
15. Birthplace South Carolina

16. Informant Mace Pennington

Address Goffney, S. C.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Oct. 30, 1946 (month) (day) (year)

Cemetery or crematory Shuford-Hatcher Co.,

Location Gaffney, S.C.

18. Funeral director Howard K. McComas,

Address Abingdon Md.

19. Oct 30 1946 (Date rec'd by registrar) Marvin Mouledale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1946, at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Lamey M. D.
Asst. Medical Examiner
M. D. or other

Address Aberdeen, Md. Date signed Oct 25, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

- THIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

10064

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred: 912 So. Union Ave
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 912 So Union Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME Mary Loraine Pennington

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Dr. Lee Roberts Pennington
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 8 1871

8. AGE: Years 75 | Months 7 | Days 29 | If less than one day: — hrs. — min.

9. Birthplace: Del. (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business: —

FATHER
12. Name: Josiah G. Heudett
13. Birthplace: Del

MOTHER
14. Maiden name: Margaret Stolsenberg
15. Birthplace: Del.

16. Informant: Mrs. Carroll Pennington
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1946 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace

18. Funeral director: E. Madison Mitchell
Address: Havre de Grace, Md.

19. Oct. 8 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7 1946, at 6 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940, to Oct. 7, 1946 and that I last saw her alive on Oct. 7, 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Diabetes Mellitus	
Due to: Cardio-Vascular Changes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: A. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed: 10-8-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460 1

CERTIFICATE OF DEATH

★ 10065

Reg. Diat. No. 182

1. PLACE OF DEATH:
County Harford Co
City or town Black Horse
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Black Horse
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cecil Otha Phillips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

B.(b) Name of husband or wife Bernice F Phillips
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1897

8. AGE:

Years	Months	Days	If less than one day
49			hrs. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Rev J J Phillips
13. Birthplace W. Va

MOTHER 14. Maiden name Mary Walton
15. Birthplace W. Va

16. Informant Mrs Bernice F Phillips
Address White Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25/46 (month) (day) (year)
Cemetery or crematory Mt Zion
Location Fountain Green

18. Funeral director Dean & Foster
Address Bel Air Md

19. 10/23 1946 Priscilla Fowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1946, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 1946, to Oct 22, 1946.
and that I last saw him alive on Oct. 22, 1946.

Immediate cause of death	DURATION
Gastric hemorrhage	2 days
Due to Carcinoma of the stomach,	6 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Stomach Date of op. 9-5-46

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

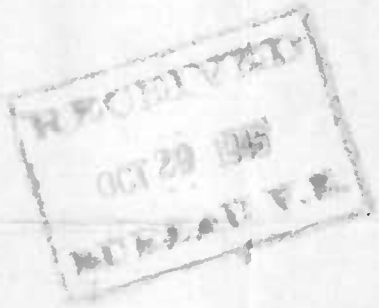
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles A. Neff M.D.
M. D. or other
Address Street, Md. Date signed 10-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10066

CERTIFICATE OF DEATH

Reg. Dist. No. 18d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: HARFORD

City or town: EDGEWOOD - RURAL (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: WILLOUGHBY BEACH

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: HARFORD

City or town: EDGEWOOD - RURAL (If outside city or town limits, write RURAL and give nearest town)

Street No. WILLOUGHBY BEACH (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ~~Hazel Marie~~ Hazel Marie Sexton ~~Sexton~~

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: James N. Sexton

~~[illegible]~~ 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 17, 1902

8. AGE: Years	Months	Days	If less than one day
43	11	3	hrs. min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: George L. Hanshew

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Annabell Wiseman

15. Birthplace: Virginia

16. Informant: James N. Sexton

Address: Edgewood, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) October 22, 1946

Cemetery or crematory: Mountain Christian

Location: Harford County

18. Funeral director: Howard K. McComas & Son

Address: Abingdon, Md.

19. (Date rec'd by registrar) Oct. 22, 1946 Registrar: Mary M. Markdale

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 20, 1946, at 4:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. J. Lamney M.D.

Address: Aberdeen, Md. M. D. or other: Asst. Medical Examiner

Date signed: Oct. 21, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

★ 10067

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County Harford
City or town Darlington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. F. D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charlotte Ann Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife Wm Vincent Smith
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) September 1872

8. AGE: Years 74 | Months X | Days X | If less than one day ..... hrs. ..... min.

9. Birthplace Darlington, Harford, Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Stephen F. Wilson
13. Birthplace Darlington, Md

MOTHER
14. Maiden name Hannah Prestbury
15. Birthplace Darlington, Md

16. Informant Mrs Hannah Taylor
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5, 1946 (month) (day) (year)
Cemetery or crematory Hosanna
Location Darlington, Md
18. Funeral director Clyde E Bedlock
Address 566 Lewis St Havre de Grace
19. Oct 5, 1946 (Date rec'd by registrar) M. W. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1946, at 7:25a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1946, to Oct 1 1946
and that I last saw h.er alive on Oct 1 1946

Immediate cause of death	DURATION
nephrosclerosis	3-11-46
Due to arteriosclerosis	3-11-46
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Claude L Brown M.D.
M. D. or other
Address Harve de Grace Date signed 10-1 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

837

10068

Reg. Dist. No. 1830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Edgewood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Edgewood (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alice M. Smithson

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: John Smithson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 4 1859

8. AGE: Years: 86 Months: 10 Days: 16 If less than one day ..... hrs. ..... min.

9. Birthplace: Winchester Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER 12. Name: William Seabrooks

FATHER 13. Birthplace: Winchester Va

MOTHER 14. Maiden name: Sarah E. Campbell

MOTHER 15. Birthplace: Winchester Va

16. Informant: Lawrence Smithson

Address: White Hall Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 23 1946 (month) (day) (year)

Cemetery or crematory: Fawn Grove Pa

Location: Fawn Grove Pa

18. Funeral director: H. Howard Webb

Address: Fawn Grove Pa

19. Oct. 23 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 1946 at 9 a.m. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 13 1946 to Oct. 20 1946

and that I last saw her alive on Oct. 19 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	1 week
Due to	
Due to	
Other conditions: Hypertension Arterio sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: C. M. France M. D. or other

Address: Parkton, Md. Date signed: 10-20-46

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ 10069

Reg. Diat. No. 1821

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Pylesville Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Pylesville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Grace Stokes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife: Henry C. Stokes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31 - 1865

8. AGE:

Years	Months	Days	If less than one day
81	2	27	..... hrs. ..... min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: David B. Harry
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Mabie J. Farver
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. Wilson Heaps
Address: Pylesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31-1946 (month) (day) (year)

Cemetery or crematory: Pylesville cemetery

Location: Delta, Pa.

18. Funeral director: Hubert P. Darkens

Address: Delta, Pa.

19. Oct. 30 19 46 M. M. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 19 46 at 1:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 44 to Oct 28 19 46

and that I last saw h.... alive on Oct 27 19 46.

Immediate cause of death	DURATION
Myocardial failure	
Due to: Arteriosclerotic CV Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Josiah A. Hunt M.D.
M. D. or other

Address: Cardiff Md Date signed 10/29/46

2-25

2-1820

2-10